DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 5

2. STATE: NV

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902.a.15, 1902.aa

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 50
b. FFY 2002 $ 100

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 1 and 1a and 1b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, pages 1 and 1a

10. SUBJECT OF AMENDMENT:
Establishment of a prospective reimbursement methodology for FQHC/RHC providers

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Charlotte Crawford

13. TYPED NAME:
Charlotte Crawford

14. TITLE:
Director, DHR

15. DATE SUBMITTED:

16. RETURN TO:
John Liveratti, Chief
Nevada Medicaid
2527 No. Carson St.
Carson City, NV 89706

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 28, 2001

18. DATE APPROVED: 6/26/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE:
Associate Regional Administrator
Division of Medicaid

23. REMARKS:

PAYMENT FOR MEDICAL CARE AND SERVICES

1. Inpatient hospital services: See Attachment 4.19-A.
2. a. Outpatient hospital services: as indicated for specific services listed elsewhere in this attachment, e.g., physicians' services, prescribed drugs, therapy services.
   b. (This paragraph intentionally left blank.)
   c. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC): FQHC and RHC reimbursement will adhere to section 1902(a) of the Social Security Act as amended by Section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA). The reasonable cost-based reimbursement requirements for FQHC/RHC services previously described at paragraph (13)(C) are repealed and instead a prospective payment system (PPS) consistent with paragraph (15) payment described in section 1902(aa) of the Act for FQHCs/RHCs is implemented. The Medicaid Prospective Payment System is to take effect on January 1, 2001.

   In the period before a prospective rate is fully implemented, interim payments will be based on the current Medicare audited core rates.

   During the period January 1, 2001 to September 30, 2001, the State will pay current FQHCs/RHCs 100 percent of the average of their per visit reasonable costs of providing Medicaid-covered services during the FQHC/RHC fiscal year 1999 and fiscal year 2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during Federal fiscal year 2001 by the FQHC/RHC. The per visit rate is calculated using 100 percent of costs for Medicaid coverable services which are reasonable. These costs are added together for each year separately, then those individual year rates are added together and divided by two. Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous fiscal year, adjusted by the percentage increase (or decrease) in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any documented increase (or decrease) in the scope of services furnished by the FQHC/RHC during that center/clinic's fiscal year which has been reviewed and agreed upon by the State. Documentation to support an increase or decrease in the scope of services is the responsibility of the provider. Newly qualified FQHCs/RHCs after Federal fiscal year 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent areas with similar caseloads and/or scope of services. Once their average per visit reasonable costs of providing Medicaid-covered services based on their first full year of operation can be determined, this data will be used to establish supplemental payments or recoveries from the provider and to establish a prospective per visit rate which will be adjusted by the percentage change in the Medicare Economic Index (MEI) for primary care services adjusted to take into account any documented increase (or decrease) in the scope of services furnished by the FQHC/RHC during that Center/clinic's fiscal year which has been reviewed and agreed upon by the State.

   The State may, at its discretion and with the agreement of the FQHC/RHC, establish an alternative payment rate at least equal to the prospective rate under PPS methodology based on the center/clinic's allowable cost as established through cost reporting methods or Attachment 4.19 B Page 7a. After the initial year, a center/clinic with a rate established by an alternate payment method FQHC/RHC, except as outlined above detailed in Attachment 4.19 B Page 7a, is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled in the previous fiscal year, adjusted by the percentage change in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC/RHC during that fiscal year.

Supplemental Payments for FQHCs/RHCs selecting the PPS methodology

FQHCs/RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for furnishing such services, that are an estimate of the difference between the payments the FQHC/RHC receives from MCE(s) and the payments the FQHC/RHC would have received under the BIPA PPS methodology. At the end of each FQHC's/RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the PPS. The FQHC/RHC will be paid the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC/RHC will refund the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the PPS amount is less than the total amount of supplemental and MCE payments.

Supplemental Payments for FQHCs/RHCs selecting the alternative methodology

FQHCs/RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services, that are an estimate of the difference between the payments the FQHC/RHC receives from MCE(s) and the payments the FQHC/RHC would have received under the alternative methodology. At the end of each FQHC's/RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the alternative methodology. The FQHC/RHC will be paid the difference between the amount calculated using the alternative methodology and actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the alternative amount exceeds the total amount of supplemental and MCE payments. The FQHC/RHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the alternative amount is less than the total amount of supplemental and MCE payments.

In the period before a prospective rate is fully implemented, interim payments will be based on the current Medicare audited cost rates.

During the period January 1, 2001 to September 30, 2001, the State will pay current FQHCs/RHCs 100 percent of the average of their reasonable costs of providing Medicaid-covered services during fiscal year 1999 and fiscal year 2000, adjusted as outlined above to take into account any increase (or decrease) in the scope of services furnished during fiscal year 2001 by the FQHC/RHC.

3. Laboratory and x-ray services: lower of a) billed charge, or b) fixed fee per unit value of the 1974 California Relative Value Studies (CRVS) as modified by implementation of Current Procedural Terminology.
4. a. Skilled nursing facility services for age 21 and over: see Attachment 4.19-D.
   b. Early and periodic screening: lower of a) billed charge, or b) fixed fee per unit value of the 1974 CRVS as modified; diagnosis and treatment: as indicated for specific services listed elsewhere in this attachment.
   c. Family planning services and supplies: as indicated for specific services listed elsewhere in this attachment, e.g., physicians' services, prescribed drugs.